		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038687

Facility Name: Blu-Fountain Manor

Address: 1623-29 W. Delmar (Number) Godfrey (City) 62035 (Zip Code)

County: Madison

Telephone Number: (618) 466-0443 **Fax #** (618) 466-9151

IDPA ID Number: 95-3750883002

Date of Initial License for Current Owners: 12/31/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Elizabeth Ogdon **Telephone Number:** (877) 823-8375 ext 4369

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/31/01 (Date)
(Type or Print Name) Greg Swartz
(Title) Director of Financial Services

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 01/01/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,888	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,888	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,740	7,997	1,133	22,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,740	7,997	1,133	22,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.89%

D. How many bed-hold days during this year were paid by Public Aid?
65 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,133

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	102,087	5,526	6,842	114,455		114,455	2,273	116,728			1
2	Food Purchase		98,144		98,144		98,144	(5,630)	92,514			2
3	Housekeeping	56,396	7,473	125	63,994		63,994	(43)	63,951			3
4	Laundry	40,640	10,247	307	51,194		51,194		51,194			4
5	Heat and Other Utilities			55,900	55,900	2,008	57,908	1,050	58,958			5
6	Maintenance	18,789	5,394	27,379	51,562		51,562	39	51,601			6
7	Other (specify):*											7
8	**TOTAL General Services**	217,912	126,784	90,553	435,249	2,008	437,257	(2,311)	434,946			8
	B. Health Care and Programs											
9	Medical Director			7,770	7,770		7,770		7,770			9
10	Nursing and Medical Records	752,894	66,232	23,457	842,583	(2,261)	840,322	(513)	839,809			10
10a	Therapy		59	115,799	115,858		115,858	(15,553)	100,305			10a
11	Activities	27,835	2,456	4,177	34,468		34,468	1,172	35,640			11
12	Social Services	36,480	1		36,481		36,481		36,481			12
13	Nurse Aide Training											13
14	Program Transportation			1,338	1,338		1,338		1,338			14
15	Other (specify):*	3,004			3,004		3,004		3,004			15
16	**TOTAL Health Care and Programs**	820,213	68,748	152,541	1,041,502	(2,261)	1,039,241	(14,894)	1,024,347			16
	C. General Administration											
17	Administrative					59,446	59,446		59,446			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			29,878	29,878		29,878	(4,660)	25,218			20
21	Clerical & General Office Expenses	98,575	11,445	159,717	269,737	(58,766)	210,971	3,127	214,098			21
22	Employee Benefits & Payroll Taxes			218,136	218,136		218,136	8,828	226,964			22
23	Inservice Training & Education			6,517	6,517		6,517		6,517			23
24	Travel and Seminar			2,574	2,574		2,574	264	2,838			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,376	30,376		30,376	10,100	40,476			26
27	Other (specify):*			1,569	1,569		1,569	(65)	1,504			27
28	**TOTAL General Administration**	98,575	11,445	448,767	558,787	680	559,467	17,594	577,061			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,136,700	206,977	691,861	2,035,538	427	2,035,965	389	2,036,354			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Blu-Fountain Manor #0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,718	35,718	4,196	39,914		39,914			30
31	Amortization of Pre-Op. & Org.			4,196	4,196	(4,196)						31
32	Interest			85	85		85		85			32
33	Real Estate Taxes			9,337	9,337		9,337		9,337			33
34	Rent-Facility & Grounds			277,859	277,859	(629)	277,230	(30,660)	246,570			34
35	Rent-Equipment & Vehicles			24,163	24,163		24,163	(114)	24,049			35
36	Other (specify):*											36
37	**TOTAL Ownership**			351,358	351,358	(629)	350,729	(30,774)	319,955			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			15	15		15		15			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51	51	(51)		37,316	37,316			42
43	Other (specify):*		4,889	901	5,790	253	6,043	(117)	5,926			43
44	**TOTAL Special Cost Centers**		4,889	967	5,856	202	6,058	37,199	43,257			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,136,700	211,866	1,044,186	2,392,752		2,392,752	6,814	2,399,566			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,213)	L-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,247)	L-21		24
25	Fund Raising, Advertising and Promotional	(4,293)	L-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(31,532)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (52,285)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	12,138	Various	34
35	Other- Attach Schedule	46,961	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 59,099		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 6,814		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Blu-Fountain Manor

ID# 0038687

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Service Charge	$ (364)	21	1
2	Bank Service Charge	(117)	21	2
3	PAC Fees	(326)	20	3
4	Magical Moments	(65)	27	4
5	Additional Facility Rent	(30,660)	34	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(31,532)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Blu-Fountain Manor # 0038687 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	1,124	1,149	0	0	0	0	0	0	0	0	0	2,273	1
2	Food Purchase	(5,630)	0	0	0	0	0	0	0	0	0	0	(5,630)	2
3	Housekeeping	(43)	0	0	0	0	0	0	0	0	0	0	(43)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	1,050	0	0	0	0	0	0	0	0	0	0	1,050	5
6	Maintenance	39	0	0	0	0	0	0	0	0	0	0	39	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,460)	1,149	0	0	0	0	0	0	0	0	0	(2,311)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	2,232	(2,745)	0	0	0	0	0	0	0	0	0	(513)	10
10a	Therapy	(15,553)	0	0	0	0	0	0	0	0	0	0	(15,553)	10a
11	Activities	0	1,172	0	0	0	0	0	0	0	0	0	1,172	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(13,321)	(1,573)	0	0	0	0	0	0	0	0	0	(14,894)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,660)	0	0	0	0	0	0	0	0	0	0	(4,660)	20
21	Clerical & General Office Expenses	(9,435)	12,562	0	0	0	0	0	0	0	0	0	3,127	21
22	Employee Benefits & Payroll Taxes	8,828	0	0	0	0	0	0	0	0	0	0	8,828	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	264	0	0	0	0	0	0	0	0	0	0	264	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	10,100	0	0	0	0	0	0	0	0	0	0	10,100	26
27	Other (specify):*	(65)	0	0	0	0	0	0	0	0	0	0	(65)	27
28	**TOTAL General Administration**	5,032	12,562	0	0	0	0	0	0	0	0	0	17,594	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,749)	12,138	0	0	0	0	0	0	0	0	0	389	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Blu-Fountain Manor** **#** **0038687** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(30,660)	0	0	0	0	0	0	0	0	0	0	(30,660)	34
35	Rent-Equipment & Vehicles	(114)	0	0	0	0	0	0	0	0	0	0	(114)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,774)	0	0	0	0	0	0	0	0	0	0	(30,774)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	37,316	0	0	0	0	0	0	0	0	0	0	37,316	42
43	Other (specify):*	(117)	0	0	0	0	0	0	0	0	0	0	(117)	43
44	**TOTAL Special Cost Centers**	37,199	0	0	0	0	0	0	0	0	0	0	37,199	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,324)	12,138	0	0	0	0	0	0	0	0	0	6,814	45

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services, Inc. (Owns 100% of Beverly Enterprises-Illinois, Inc.)	100.00	More than 500 facilities across the United States				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Home Office Costs	$ 135,257	Beverly Enterprises - Illinois, Inc.	100.00%	$ 147,819	$ 12,562	1
2	V	11	Social Services Consultant		Beverly Enterprises - Illinois, Inc.	100.00%	1,172	1,172	2
3	V	10	Nursing Consultant	12,937	Beverly Enterprises - Illinois, Inc.	100.00%	10,192	(2,745)	3
4	V	1	Dietary Consultant		Beverly Enterprises - Illinois, Inc.	100.00%	1,149	1,149	4
5	V	3	Housekeeping Consultant		Beverly Enterprises - Illinois, Inc.	100.00%			5
6	V	10	Nursing Consultant		Beverly Enterprises - Illinois, Inc.	100.00%			6
7	V	6	Maintenance Consulting		Beverly Enterprises - Illinois, Inc.	100.00%			7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 148,194			$ 160,332	$ * 12,138	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehab Svcs, Inc.
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (501) 201-2000
Fax Number: (501) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Corporate HO Cost & QA	Resident Days	93,674	3	$ 478,328	$	22,935	$ 117,113	1
2	21	Regional Cost & QA	Resident Days	93,674	3	125,497	2,720	22,935	30,706	2
3										3
4	11	Corporate HO Cost & QA	Resident Days	93,674	3	4,787	3,775	22,935	1,172	4
5	11	Regional Cost & QA	Resident Days	93,674	3	0	0	22,935	0	5
6										6
7	10	Corporate HO Cost & QA	Resident Days	93,674	3	4,280	3,260	22,935	1,048	7
8	10	Regional Cost & QA	Resident Days	93,674	3	37,348	0	22,935	9,144	8
9										9
10	1	Corporate HO Cost & QA	Resident Days	93,674	3	4,693	3,709	22,935	1,149	10
11	1	Regional Cost & QA	Resident Days	93,674	3			22,935	0	11
12										12
13	3	Corporate HO Cost & QA	Resident Days	93,674	3			22,935	0	13
14	3	Regional Cost & QA	Resident Days	93,674	3			22,935	0	14
15										15
16	10	Corporate HO Cost & QA	Medicare Days	3,545	3			1,133	0	16
17	10	Regional Cost & QA	Medicare Days	3,545	3			1,133	0	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 654,933	$ 13,464		$ 160,332	25

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4	CCA Financial, Inc. (Turbolan		X	Acquisition of Equipment	See attached Capital Lease Agreement						86	4
5	Lease)											5
	Working Capital											
6												6
7	Patient Related Interest Income		X								(1)	7
8												8
9	TOTAL Facility Related						$	$			$ 85	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 85	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Blu-Fountain Manor # 0038687 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	25,160	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	22,315	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,845)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	11,826	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	9,337	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	21,451	8
	1996	22,925	9
	1997	24,075	10
	1998	21,906	11
	1999	22,315	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,144 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	N/A	1985	$	1
2					2
3	TOTALS	#VALUE!		$	3

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	41,060	2,361	20	2,361		24,179	9
10	(See depreciation schedule for detail of items)			1994	3,300	259	15	259		1,695	10
11				1995	13,380	977	15	977		5,607	11
12				1996	12,789	1,351	15	1,351		5,973	12
13				1997	171,255	17,734	10	17,734		59,539	13
14				1998	26,576	2,424	15	2,424		5,715	14
15				2000	2,591	117	10	117		117	15
16											16
17	Computer & Related Equipment			1994	7,953		5			7,953	17
18				1995	2,022	303	5	303		2,022	18
19				1998	9,297	2,028	7	2,028		4,756	19
20				2000	1,255	128	5	128		149	20
21											21
22	Software Development Cost			1990	1,121		5			1,121	22
23				1991	7,237		5			7,237	23
24				1994	3,920		5			3,920	24
25				1998	6,042	230	10	230		1,694	25
26				1999	31,108	3,845	10	3,845		6,772	26
27				2000	2,412	121	5	121		121	27
28											28
29	Computer Equipment Capital Lease			1999	804	161	5	161		188	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 344,122	$ 32,039		$ 32,039	$	$ 138,758	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 81,711	$ 7,725	$ 7,725	$	5 to 10	$ 26,797	37
38	Current Year Purchases	2,787	150	150		5 to 10	150	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 84,498	$ 7,875	$ 7,875	$		$ 26,947	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 428,620	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 39,914	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 39,914	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 165,705	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		68	12/31/85	$ 246,570			3
4	Additions							4
5								5
6								6
7	TOTAL		68		$ 246,570 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purch of all facilities from Encore *

10. Effective dates of current rental agreement:
Beginning 01/01/1998
Ending 12/31/2001

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 139,608
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 20,008 Description: See Next Page for Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	96 Ford Windstar	$ 337.00	$ 4,041	17
18					18
19					19
20					20
21	TOTAL		$ 337.00	$ 4,041	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Blu-Fountain Manor # 0038687 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,179	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 9,470)	409,705		3
4	Supply Inventory (priced at historical cost)	29,697		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 448,581	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	344,122		15
16	Equipment, at Historical Cost	84,498		16
17	Accumulated Depreciation (book methods)	(165,705)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 262,915	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 711,496	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (13,318)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,511		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,853		31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,826		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Garnishment Withheld	4,278		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 64,150	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	(182,916)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (182,916)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (118,766)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 830,262	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 711,496	$	48

***(See instructions.)**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 833,351	1
2	Restatements (describe):		2
3	**Remove Prior Year Adj-Home Office & Dist Center Equity**	244,312	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,077,663	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,153)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(223,248)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (247,401)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 830,262	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,316,914	1
2	Discounts and Allowances for all Levels	(144,077)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,172,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,366	6
7	Oxygen	157	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,523	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,563	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,618	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,289	19
20	Radiology and X-Ray	341	20
21	Other Medical Services	8,231	21
22	Laundry	2,420	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,462	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Patient Personal Needs, Other Misc Rev	777	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 777	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,368,599	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	435,249	31
32	Health Care	1,041,502	32
33	General Administration	558,787	33
	B. Capital Expense		
34	Ownership	351,358	34
	C. Ancillary Expense		
35	Special Cost Centers	(31,460)	35
36	Provider Participation Fee	37,316	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,392,752	40
41	**Income before Income Taxes (line 30 minus line 40)****	(24,153)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (24,153)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,166	2,166	$ 47,435	$ 21.90	1
2	Assistant Director of Nursing	2,339	2,483	45,340	18.26	2
3	Registered Nurses	9,246	10,162	160,356	15.78	3
4	Licensed Practical Nurses	10,039	11,250	147,038	13.07	4
5	Nurse Aides & Orderlies	43,389	45,941	340,425	7.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,608	2,754	22,362	8.12	9
10	Activity Assistants	1,836	2,212	14,599	6.60	10
11	Social Service Workers	2,326	2,556	28,372	11.10	11
12	Dietician	3,555	5,745	36,711	6.39	12
13	Food Service Supervisor	2,796	3,248	30,434	9.37	13
14	Head Cook	5,222	5,636	38,776	6.88	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,094	2,222	19,865	8.94	17
18	Housekeepers	8,606	9,416	60,922	6.47	18
19	Laundry	5,490	6,049	40,347	6.67	19
20	Administrator	2,080	2,080	59,446	28.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,885	2,096	22,427	10.70	23
24	Clerical	1,375	1,445	10,606	7.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,689	1,713	11,239	6.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,741	119,174	$ 1,136,700 *	$ 9.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 6,842	L-1,3	35
36	Medical Director		7,770	L-9,3	36
37	Medical Records Consultant		912	L-10,3	37
38	Nurse Consultant		531	L-10,3	38
39	Pharmacist Consultant		3,669	L-10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,724		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donald Dill	Executive Director	0	$ 59,446
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,446

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,600
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	55,888
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Injury	
Payroll Taxes	104,943
Retirement Expense	195
Employee Fringe Benefits	9,390
Workers' Compensation Ins Adjust	(8,291)
Medical/Dental Ins Adjust	16,238
Rounding	1
TOTAL (agree to Schedule V, line 22, col.8)	$ 226,964

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 150
Advertising: Employee Recruitment	25,905
Health Care Worker Background Check	
(Indicate # of checks performed 0)	992
Dues and Subscriptions	
Advertising and Public Relations	4,293
Community Education	(1,503)
Less: PAC Fees	(326)
Less: Public Relations Expense	( )
Non-allowable advertising	(4,293)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,218

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	437
Meals	2,401
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,838

**See instructions.

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Blu-Fountain Manor # 0038687 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association** **$2784**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,374** Line **10, Col 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **37,316**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,560**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **32%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available until later in the year**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.